Patient Intake Form

(Please Print)

Full Name _____ Social Security #_____ Sex: [] Male [] Female
Address _____ City _____ State_____ Zip_____
Date of Birth_____ email_____ Marital Status: _____
Home Phone _____ Cell Phone _____ Work _____
Occupation/Employer _____ Business City/St/Zip_____
How did you hear about us? __Internet __Family/Friend __Referral __Other_____
Whom can we thank for referring you to us? _____

If insured, an insurance card will be required on the first visit so we may verify your benefit eligibility on your behalf. The following information is required by most insurance companies:

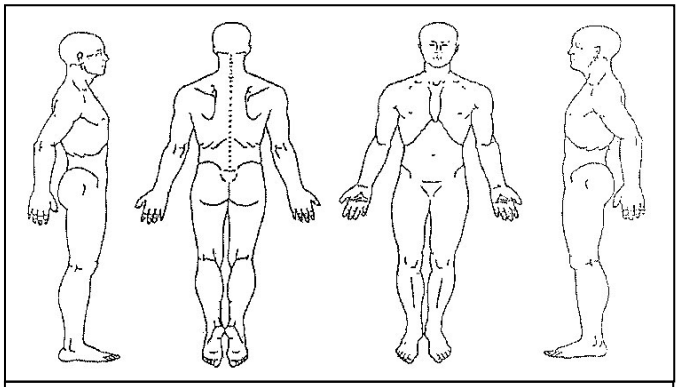
Name of Insured _____ Relationship to Patient_____
Date of Birth_____ SSN_____ Insurance Comp_____
Policy # _____Group #_____
Is this condition due to an accident? [] Yes [] No Type of Accident: [] Work Injury [] Auto Accident [] Sport [] Other

Emergency Contact Name_____ Relationship to Patient_____
Phone Number: Work _____Home_____

SUBJECTIVE (please fill out completely)

Reason For Today's Visit _____
My Complaint is best described as: __Pain __Numbness __Swelling __Muscle Spasms __Headache __Tightness __Stiffness
WHEN did you first notice your condition? _____ OR __Not Sure
The CAUSE of the injury(s): __Trauma __Repetitive Actions __Auto Accident __Post-Surgical Complication __Unspecified Reason __Other_____
The QUALITY of my main complaint is BEST described as: __Sharp __Dull __Aching __Throbbing __Crushing __Stabbing __Burning __Shooting __Other_____
My headaches, if any, are best described as: __Migraine __Tension __Hormonal __Sinus __Organic
I experience my complaint: __Constantly __Frequently __Intermittently __Occasionally

Please rate the Severity of each complaint you present with today (Please circle)…(0= No Pain,10=Extreme Pain)
1. _____ 0 1 2 3 4 5 6 7 8 9 10
2. _____ 0 1 2 3 4 5 6 7 8 9 10
3. _____ 0 1 2 3 4 5 6 7 8 9 10
4. _____ 0 1 2 3 4 5 6 7 8 9 10



Using the body chart above, indicate the region(s) of your complaint(s).

I experience my pain: __ Worse in the morning __Worse at midday __Worse at night __Pain is consistent all day
Describe what makes your condition feel better (Heat / Ice / Rest / Sleep / Positions) _____
Have you had this condition before? [] Yes [] No
If yes, When? _____

Describe any prior treatment for this condition_____
What is/are your health goal(s)? _____
List ALL previous Surgeries: _____
List ALL Drugs/Medications you currently use (prescription and over-the-counter) _____
_____
List Any Vitamins/Supplements you are currently using _____
_____

Supplemental Health History

Please mark the appropriate box for any current or previous health conditions

Musculoskeletal
- ❑ Auto Accidents
___0-1 years ago
___1-5 years ago
___More than 5 years ago
- ❑ Fractured Bones
- ❑ Pain/Stiff Neck R / L
- ❑ Back Pain/Stiffness R / L
- ❑ Numbness/Tingling in Arms/Hands/Fingers R / L
- ❑ Numbness/Tingling in Legs/Feet/Toes R / L
- ❑ Swollen/Painful Joints
- ❑ Difficulty with Prolonged Standing, Walking, Driving
- ❑ Difficulty Performing Daily Activities
- ❑ Back Curvature
- ❑ Arthritis
- ❑ Jaw Pain/TMJ R / L
- ❑ Foot Trouble R / L
- ❑ Hip Pain R / L

Neurological
- ❑ Convulsions/Epilepsy
- ❑ Learning Disability
- ❑ Loss of Balance
- ❑ Dizziness
- ❑ Ringing in Ears R / L
- ❑ Trouble Concentrating
- ❑ Irritable
- ❑ Fainting
- ❑ Hearing Lost R /L
- ❑ Tremors
- ❑ Double Vision R / L
- ❑ Trouble Sleeping
- ❑ Blurred Vision R / L
- ❑ Headache
- ❑ Pain with cough/sneeze
- ❑ Mood Changes
- ❑ Depressed
- ❑ Eating Disorders

Digestive
- ❑ Diarrhea/Constipation
- ❑ Heartburn
- ❑ Colon Trouble
- ❑ Gall Bladder Trouble
- ❑ Diabetes
- ❑ Ulcers
- ❑ Hemorrhoids

Immune
- ❑ Frequent Colds/flu
- ❑ Difficulty Breathing
- ❑ Asthma
- ❑ Ear Infection
- ❑ Allergies
- ❑ Cancer
- ❑ AIDS/HIV

Other Systems
- ❑ Kidney Trouble
- ❑ Chest Pain
- ❑ Lung Problems
- ❑ Heart Problems
- ❑ Liver Trouble
- ❑ High/Low Blood Pressure
- ❑ Stroke
- ❑ Anemia
- ❑ Bed Wetting
- ❑ Prostate Problems
- ❑ Skin Problems
- ❑ Thyroid Problems
- ❑ Varicose Veins
- ❑ Menopausal Problems
- ❑ Menstrual Problems/PMS
- ❑ Pregnant
- ❑ Endometriosis
- ❑ Ovarian/Uterine Cysts

EXERCISE
- ❑ None — Types of Exercise
- ❑ Moderate _____
- ❑ Daily _____
- ❑ Heavy _____

WORK ACTIVITY
- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

HABITS
- ❑ Smoking — Packs/Day _____
- ❑ Alcohol — Drinks/week _____
- ❑ Coffee/Caffeine — Cups/Day _____
- ❑ High Stress Level — Reason _____

ACTIVITIES OF DAILY LIVING

ACTIVITY	No Pain	Mild Pain	Tolerable Pain	Moderate Pain	Severe Pain	Disabling Pain
Walking	❑	❑	❑	❑	❑	❑
Sitting	❑	❑	❑	❑	❑	❑
Bending	❑	❑	❑	❑	❑	❑
Standing	❑	❑	❑	❑	❑	❑
Sleeping	❑	❑	❑	❑	❑	❑
Lifting	❑	❑	❑	❑	❑	❑
Running	❑	❑	❑	❑	❑	❑
Climbing Stairs	❑	❑	❑	❑	❑	❑
Carrying	❑	❑	❑	❑	❑	❑
Driving	❑	❑	❑	❑	❑	❑
Dressing	❑	❑	❑	❑	❑	❑
Reading	❑	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑	❑
Gardening	❑	❑	❑	❑	❑	❑
Sports	❑	❑	❑	❑	❑	❑
Sitting to Standing	❑	❑	❑	❑	❑	❑
Rolling Over	❑	❑	❑	❑	❑	❑
Computer Work	❑	❑	❑	❑	❑	❑

The above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use you health information within our practice for quality control or other operational purposes.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Craig Hite, D.C. of all benefits that may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.

Furthermore, I hereby IRREVOCABLY ASSIGN to Craig Hite, D.C. the rights and benefits under any policy of insurance, indemnity agreement, and/or charges provided by Craig Hite, D.C.

Authorization to Release Medical Record Information:

Craig Hite, D.C. is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Craig Hite, D.C. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Craig Hite, D.C.

I have read your consent policy and agree to its terms. I am also acknowledging that I may receive a copy of this notice at anytime and that the original will remain in my medical record.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

Hite Chiropractic

Chiropractic, Physical Therapy & Massage

Thank you for choosing Hite Chiropractic, Physical Therapy and Massage. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to any treatment. This financial policy applies to all services rendered by all providers in our office.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any co-pay/co-insurance due at the time services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

If you are insured with a plan which we are contracted with, you will need to pay for any non-covered services, any outstanding deductible and co-pay/co-insurance at the time of you visit. Failure to pay outstanding balance within 90 days of notification of the amount due will result in collection proceedings unless prior arrangements are made.

All patients that do not have insurance, payment is due at the time services are rendered. For your convenience we accept all major credit cards. If you should have any further questions, we will be glad to assist you.

24-Hour Cancellation/Rescheduled Policies of Appointment

24-hour advance notice is required when cancelling or rescheduling a Massage Therapy appointment. If you are unable to give us at least 24 hours advance notice **you will be charged $45** for a missed Massage Therapy appointment or **$25** for a missed Chiropractic appointment.

I have reviewed the attached personal information and confirm that all the information is accurate.

"I have read, understand and agree to the provisions of this policy."

_____	_____	_____
Patient Name	Signature Patient/Guardian	Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Craig Hite, D.C. and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Craig Hite, D.C. the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

Print Patient's Name _____

Signature of Patient _____

To be completed by the patient's
representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)

Print Name of Patient _____

Print Name of Representative _____

Signature of Representative _____

This form should be maintained in the patient's health record.